# AZ HIPAA Medicaid Consortium

**February 11, 2004**
**2:00 PM to 4:00 PM**
**AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room**

**Meeting Hosted By**: Lori Petre, AHCCCS

**Attendees:**

***(Based on sign-in sheets)***

| | | |
|---|---|---|
| **ADHS/BHS** | *Lydia Ruiz* | **IHS** |
| *Thomas Browning* | *Marsha Solomon* | *Charlotte Melcher* |
| *Lee Cisney* | *Pat Spencer* | **MCP & Schaller Anderson** |
| *Jerri Gray* | *Carrie Stamos* | *Anne Romer* |
| *Brian Hiese* | *Eric Stott* | *Art Schenkman* |
| *C.J. Major* | *Linda Stubblefield* | **Maricopa** |
| **AHCCCS** | *Del Swan* | *Dave Abraham* |
| *Peggy Brown* | *Mike Upchurch* | **PHP** |
| *Deborah Burrell* | *Nancy Upchurch* | *Greg Lucas* |
| *Barbara Butler* | **APIPA** | *JoAnn Ward* |
| *Melonie Carnegie* | *Sean Stepp* | **PHS** |
| *Michelle Dillon* | *Sharon Zamora* | *Mark Hart* |
| *Tom Forbes* | **DES** | **UFC** |
| *Matt Furze* | *Marcella Gonzalez* | *Eric Nichols* |
| *Patti Goodwin* | *Stan Hime* | *John Valentino* |
| *Chris Herrick* | *Major Williams* | **Verizon** |
| *Ester Hunt* | *Nicole Yarborough* | *Larry Bryce* |
| *Bruce Jameson* | **Evercare Select** | |
| *Ted Kowalczyk* | *Ramkumar Manakal* | |
| *Dan Lippert* | **Healthchoice AZ** | |
| *MaryKay McDaniel* | *Paul Benson* | |
| *Nancy Mischung* | *Ethan Schweppe* | |
| *John Nystedt* | *Mike Urchin* | |
| *Brent Ratterree* | **HCSD** | |
| *Marna Richmond* | *Michael Wells* | |

**1. Welcome (Lori Petre)**

There are quite a few things on the agenda today. If at all possible, we will try to get you out of here early today or at a minimum on schedule. Everyone should have a copy of the agenda and attachments. There are not a lot of attachments today. We are mostly going to try to provide you with some updates, discuss a few items, and we will work from there. One of the things that is attached to your packet today that is a little different is the meeting minutes from the 1/28/04 Consortium meeting. Melonie has been trying diligently to get these out the door, and they will be posted to the website shortly. We will start making these available in this meeting in addition to sending them out through the other venues.

Brent Ratterree is going to talk a little bit about Encounters and NCPDP. We asked Del Swan, who is our resident Pharmacy expert here at AHCCCS to join us to lend his insights into that particular topic area.

**2. Encounters NCPDP (Brent Ratterree)**

I know there have been some questions whether or not we are going to be using 5.1. There has been a lot of interest, as you may know, from the legislature and the Governor's office about pharmacy. They have been asking questions that we cannot answer with the current layout that we have. That is one of the reasons that we have pursued the 5.1 transaction is to be able to react quickly to that information that they may want. We are pursuing the 5.1 transactions for Encounters and fee-for-service claims. ISD has provided a requirements document handout of this transaction to sort of ease you through some of those mapping decisions. MaryKay will discuss this handout in detail a little later.

Q: Is the submission date going to be the 16th day each month?
A: You can submit anytime that you want. We gather information every day, load it into a staging area, and from that staging area it is the first Saturday after the first Wednesday of the month that we will process that information through a cycle. We then provide you with output generally within a week after that. Our acceptance of the Encounter data will not change. You can still transmit that to us anytime that you want. The current encounter submission, because we are doing data certification, is due on the Friday after the first Wednesday of the month. So for example, in February it was the 6th. If you got the information to us that day, it would be processed for February. If it comes in after that day, it is processed the following month. That is the current process.

Q: Regarding dealing with the PBMs and getting them to do the NCPDP for you. Right now the way it works for us is our PBM sends us a proprietary file for pharmacy claims, we run it through our claims adjudication system, and then from that forward on to the pharmacy encounter report. If we were to have our PBM generate the NCPDP file for us, and we don't have a translator setup for that, it puts us in a bit of a bind. If we forward that on to you as pharmacy encounter claims, and there are pends, how are we going to work the pend process in that scenario?
A: We technically do not have a translator that processes NCPDP transactions. We are creating that ourselves to run information through the system so that it looks like a 5.1.

Q: What is the file going to look like? Are you expecting to get a flat file back or an EDI file?
A: We are expecting all of those 5.1 claims to be encapsulated in a batch 1.1 file. It will be coming in as a batch.

Q: Did you see how the new information that cannot be gotten by the existing layout or marked to that layout?
A: The information that we have been requested to produce is ingredient cost, dispensing fees, co-pays, co-insurance, etc. Those are the general areas that we have been asked to produce that we can. If you are able to capture all the information in the 5.1, we can easily turn the switch

on or ask you to turn the switch on without having to wait for six months down the road for everyone to program the changes in.

Q: Maybe MaryKay is going to get into this, but after it is submitted and a pended encounter comes back, is it going to come back under the current system?
A: The pended encounter process will remain the same. Either good new, bad news, there is no national transaction to conduct pended encounters.

A couple of questions have been emailed to Lori Petre that I need to answer.

Q: A draft encounter manual shows that the contractor claim control number is not available for pharmacy reporting, and the AHCCCS control number is not available for voiding and replacing of previously processed pharmacy encounters. Can you check to see if they found a way to report this information?
A: We have not got there yet, but we are working on it.

Q: If the contractor claim control number is not available for pharmacy reporting, how will pharmacy encounters be identified in the 277U and the pend file?
A: There is a survey that went out this week to CEO's asking them to pass it down to the relevant folks to provide information for what is populating the patient account number field. Once we know that, then we can address these two questions.

Q: Regarding the 837 and sub-cap codes. One of the plans is currently using sub-cap code 02 to report services that are excluded from a sub-capitated payment arrangement with sub-capitated providers.
A: If those particular services, if you are reimbursing those services on a fee-for-service basis, then you should report those particular services as fee-for service. Meaning, do not submit the contract type. If you have any sort of capitation arrangement in there though, report the contract type or whatever that particular arrangement is, we should report that if it is available.

Q: How are you designating per diem?
A: In the current sub-cap code logic, there is no per diem code available. However, on the 837 there is so if you want to report that as a per diem arrangement, you could use that particular code or value to show us a per diem payment.

Q: Can you submit a void and a new claim in the same file?
A: Yes, you can send it in the same file.

Q: If you are voiding a claim, I assume you set this transaction code to a reversal (drug transaction). Is that correct?
A: The drug transaction is a reversal, yes.

Q: Say you adjudicated this claim months ago in the system, and now we need to void it. How do we identify that claim? Currently we use the CRN of this claim, but I don't see here how we identify this previous claim in the system.
A: We are waiting on a response on how to handle that. Worse case scenario, we could triangulate based on other data elements in order to find that particular original encounter, but I am hoping that we do not have to go that route.

Q: Can we do an adjustment without an approval?
A: No, you can only do a void and replace on something that is finalized.

Q: Do you have a TSN in the ISA segment?
A: For the current process, I would have to check the companion document specifically. There is an input mode that indicates that it is a new batch. For pended claims, you send them in as you

do today. It goes outside Mercator. I think the plan was to generate the TSN internally. I will need to check with the programmers on how this is being done.

Action Item: Brent Ratterree
To check with programmers on how this is being done.

Q: Do you want to receive an NCPDP response for each request?
A: Yes. Within each transaction, there is a request.

Q: What would Mercy Care want pricing information back from AHCCCS since you paid the claim.
A: It is the response transaction that is required.

Q: Can you translate the 277 into a 5.1 response for NCPDP? Even with that you would have to be able to tell when you got the 277 back that it was for NCPDP, and how would we head down that road?
A: There are two problems with that which have been previously discussed with other health plans before. For the health plans that are not going to be doing the 5.1 themselves, who are relying on their PBM to do it, the PBMs don't normally get response transactions back. They are usually the ones that are sending them out. If 98,000 of them go through clean, and there is only 2,000 that have an issue, they only want to look at the 2,000. What we had talked about was sending back an acknowledgement if the entire batch was basically syntactically correct, was going to run through and hit the mainframe application process to do the rest of the processing with it falling out the back end like it normally does today either as a pend or on the 277 as adjudicated or denied. The way it works today with the 5.1 transaction is the Pharmacy sends it off, and they get an immediate response. We won't be able to do that to the extent of yes, everything has passed through the mainframe side. There has not been any discussion at all about sending back the processing statuses from the mainframe side, back to Mercator, back out as a response. The response transactions that they were talking about doing was truly a response at what I am going to call the front end at Mercator or wherever that gateway is that says that 'we got the file' or 'we got the file, and there was something syntactically incorrect with it'. There was never a thought to say 'we got your file, we processed it, and here's anything that might possibly be wrong, member not on file' or those kinds of things. All that has always been intended to fall out the back end.

Q: Do you have any test NCPDP transactions?
A: No, at this point we have no test transactions. It is definitely different from the X12 transaction in that segments are not required to be in order, fields are not required to be in order, etc.

Q: Will it have the count?
A: Yes, you have the count. If you say you have a counter of four in whatever it happens to be such as four modifiers, four other ingredients, four lines, and there is not four there, then that would be a syntactical issue. You would get a response.

Q: MaryKay – Would you really rather see all responses for NCPDP come out the back end of an NCPDP response?
A: Mercy Care – My back end is request and response, so yes, but that is the way that my pharmacy processes.

MaryKay – So what I am hearing from Art, and I think that the impact would be to the rest of the plans. is that if there was no response done at the front, and everything came out the back end and it was on the 277, the problem that we will have is that if it is not syntactically correct, how do we get it through to the mainframe? We need to look at that.

Q: Are we having a dialogue about this or are you expecting a decision?

A: Lori Petre – The decision needs to come very soon so we need to have theses dialogues so you can go back and think about how some of these decisions impact you. We would like you to give it some thought and respond via email to me. I will then review the responses with Brent.

**NCPDP (MaryKay McDaniel)**

I took the NCPDP 5.1 and have the batch header and trailer on the first two pages. I just briefly want to discuss what the new layout will look like.

**Transaction Header Segment**
This is the transaction header segment in the batch that we are talking about. We will only accept a T for submitting a batch as a transmission type. The sender ID is going to be what we consider as the submitter ID which is going to the be the three byte health plan ID acronym followed by the submitter tax ID, the health plan ID, the tape supplier and then the mode. The batch number, and this is straight out of NCPDP, must be unique within all transmissions submitted to AHCCCS by the same entity. The format for it is CCYY with a Julian date. The date the file was created, the time that it was created, whether it is test or production, version will be 1.1, and the receiver ID is going to be AHCCCS followed by the federal tax ID number.

**Detail Data Record**
The detail record is what starts the record within the batch. This is appended to the very front of the on-line request. It is going to be a text indicator segment identifier as a G1 to indicate that it is the detailed data record, and a transaction reference number. The transaction reference number must be unique within the file, and it is returned in a response, which is the reason that we are going to request that it is that way.

**Transaction Number**
We are going to go to the 5.1 request, which starts on page 3. The transaction number segment includes the BIN number. The version release is 51. The transaction codes that AHCCCS will accept will be B1 – Billing, B2- Reversal, or B3-Rebill. There is processor control number that is assigned by the processor. Service Provider at the transaction level will be the AHCCCS pharmacy ID which is the 6 position ID number plus the 2 byte location number. DOS will be the dispense date, and then there is a software vendor/certification. It is my understanding that the BIN and processor control number are what uniquely identify a claim.

Health Plan – I would probably say no. They are directing it based on BIN number alone. All it is doing is telling exactly how the transaction needs to be routed to be adjudicated. There is a piece that is used to differentiate.

Q: MaryKay – Do you know what that is, the piece to differentiate?
A: Health Plan – It is called the submitter group ID under the insurance segment. It is sometimes used with pharmacy software.

Q: Brent – What about the prescription service reference number?
A: Health Plan – That in combination with the refill number will make that claim number.

Q: Why can't you send us a claim number?
A: CMS is using the processor control number as the patient account number. That came out in just this week in some notifications that I saw this morning.

The BIN number and the processor control number could be the same for every claim that comes through. We need to look at that to determine how we are going to make a uniquely identifiable claim.

Action Item: MaryKay McDaniel
Determine how we are going to make a uniquely identifiable claim.

**Patient Segment**
The other suggestion that I have heard was having the patient ID number, which is a twenty-position field, be the claim number. I don't know how everybody will feel about that idea. We were looking at having the cardholder ID as the AHCCCS ID. It is not technically a patient ID number, but it would certainly get you back to the individual. Or if you needed a patient account number, the patient ID/patient account number logically makes sense. The AHCCCS ID goes in the cardholder ID so I am throwing that out there as an option for the patient account number, if it was different than the RX number.

Q: MaryKay – What do you use as a patient account number for your pharmacies?
A: Health Plans: 1. AHCCCS ID number;
2. Claim number;
3. RX number.

Brent – Please be sure to send back that survey with all these different answers so that they can be considered.

DOB would be the recipient date of birth. The gender code is only Males and Females; other is not allowed. The rest of them on here are pretty clear. The patient location at the beginning of page 4, are not the place of service codes or the location codes that we are used to seeing on the 837. The pregnancy indicator is appreciated if known.

**Insurance Segment**
For the insurance segment, we are looking at the AHCCCS ID as the cardholder ID with the recipient first name and last name. All other optional fields are accepted should you have them filled out.

**Claim Segment**
In the claim segment, the prescription/service qualifier will be 1 for RX billing. Next will be prescription/service reference number which is the RX number. The product service ID, if it is an NDC code, it must be in the format of manufacturer drug ID and package size. Procedure modifiers, if sent, will be stored; no processing. Quantity dispensed is the quantity. Fill number is 0-99. Compound code, if it is a compound, we would really like to see the 2 indicating it was a compound formulary. Dispense as written somewhat equates to the brand yes or no field that is currently sent. We now have 0-9. Date prescription written is CCYYMMDD. Number of refills authorized cannot be more than 99. Other coverage code is new, and it will be stored as at this time there is no processing. The unit of measure which will be each, grams or milliliters.

**Pharmacy Provider Segment**
We are skipping through the pharmacy provider segment as we are not using it.

**Prescriber Segment**
The prescriber segment will be the Medicaid ID number, and the prescribers 6 digit AHCCCS ID and locator code.

**COB/Other Payments Segment**
The coordination of benefits/other payments segment is going to be clogged-up as there is a lot of information in this little segment. There can be up to nine other payers on a transaction; one of which, as it comes in to AHCCCS, we will expect to be the health plan. Within this loop you can tell us, using the other payer amount paid qualifier, an 04 is dispensing fee, an 07 the ingredient cost, 08 the actual health plan paid amount. The code 99 gets triple duty. The first occurrence of 99 in this loop for this particular payer means it is a deductible, the second occurrence means it is a co-insurance, and the third occurrence means that it is co-pay. If you need only co-pay, you have to create two occurrences of zero to get past the deductible and co-insurance to show the third with the co-pay amount.

**Worker's Compensation Segment**
Another option for the actual health plan claim number was in the worker's compensation segment. It actually has a field called the claim/reference ID. The only field that you would then have to use, in addition to that, is the date of injury, which could be the actual date of the dispensing.

Q: Was this going to be run by CMS or NCPDP for approval?
A: Brent Ratterree – I have already ran a number of issues by NCPDP. They are saying, at this point, that you can use it. CMS I only update on their transactions. Once this is finalized, there is a workgroup which is a state government workgroup that will inform them of what we will be using.

Q: I take it CMS has not finalized what there expecting in the 5.1?
A: MaryKay – CMS is in a different situation than we are. They are not getting encounters. They are actually doing real time 5.1 transactions. Yes, they have finalized that. What they did is, in the next version of the NCPDP coming out, there is a 500 byte message in the prior authorization that they have used for their certificates of medical necessity, facility ID numbers, facility addresses, that were not in other places within this transaction. That is what their vendors are using. They are using the patient account number as the processor control number. On their transaction, there is no health plan claim number.

**DUR/PPS Segment**
If the DUR/PPS segment is there, it will be okay.

**Pricing Segment**
The ingredient cost submitted would be the ingredient cost submitted by the pharmacy; not necessarily what was paid, but what was submitted by the pharmacy to the PBM. The dispensing fee submitted is the same; it what was submitted by the pharmacy and may or may not have actually been paid. The next one of interest is the patient paid amount submitted. This is what the pharmacy actually received in their register from whoever picked up that medication. The last on this segment would be the gross amount due which would be the billed amount.

Q: That was what the pharmacy submitted, not actually what the pharmacy paid?
A: On the gross amount due, this is what the pharmacy actually submitted. What we would be getting back is, in the COB for the health plan loop, the amount paid as it was an 08 qualifier will be what was actually then paid by the PBM to the pharmacy or paid by the health plan to the pharmacy. There will always be one COB repeat for the health plan. They are making the 5.1 basically a COB claim, which will contain the health plan paid amount. The billed amount here is truly the pharmacy billed amount, not the paid amount.

**Coupon Segment**
The coupon segment we are not using.

**Compound Segment**
The compound segment we are not using.

**Prior Authorization Segment**
The other place or suggestion for using or placing the health plan claim number was in the prior authorization segment. It would be in the authorization number which is a twenty position field. To do that you would have to have a request type, a request period date-begin, a request period date-end, a basis of the request which are mandatory fields before you get to that claim. You would have to fill that data.

**Clinical Segment**
We would love to see diagnosis codes, if you know it.

**Trailer Segment**
At the end of that, it would be the trailer segment which is back up on page 1. After you have got all your detail lines, you go back and you put a trailer on. Basically the batch number has to match the batch header number, and there is a record count.

Q: Just a count of the G1s?
A: That would be all. It would be the header and the trailer plus all G1s; the total number of records in that file. The batch header record is one record, all the G1 records would be counted, and then the trailer record is also a record so there would be a total of all.

The last two pages contain notes of some of the fields that are not currently on the file today.

**Patient Segment**
The DOB and the patient gender code will not be loaded into PMMIS at this time. What we are using them for is in case there is ever a need to do research on the files. It just makes it a little bit easier if you have a DOB and gender with the name. The patient location code is currently the standard place of service codes. Pregnancy indicator would really be nice, if you have it.

**Claim Segment**
Procedure modifiers will be captured, but there is nothing attached to them. The compound code is new; you have never submitted that before. Dispense as written has changed a little bit. There is no more yes/no flag; it will actually be the code. The other coverage code, they want the actual two digit code segments to go in there rather than a yes/no if the person had other coverage. Unit of measure is new.

**COB/Other Payments Segment**
The other payer ID is new as well as the other payer date. The other payer amount paid qualifier is where we are going to get dispensing fees, ingredient cost, paid amount, and the co-pays.

**Pricing Segment**
The next three are the ingredient cost submitted, the dispensing fee submitted and the patient paid amount submitted.

**Clinical Segment**
The last is the diagnosis code.

Q: What you see here as mandatory and optional, is it NCPDP mandatory or optional?
A: Correct.

Lori Petre - That is the type of information that we have put in the companion guide. Any kind of optional fields that for business reasons we are requiring will be outlined in the companion guide. What we need to do is get out the things that we know are open issues, and the options that we have identified. In looking at this, and in your experience, you have other suggestions, then let us know. If there are other issues or concerns that you have, we need to know about those now as we do not want to get started on the planning process only to find out later that you cannot use this at all.

Q: Can we quickly run through again the options for the health plan claim ID?
A: Lori Petre – Yes, and we will follow-up with an email either this afternoon or first thing tomorrow.

There are six options that we will be sending out so you can vote on them. They are 1) Detail Data Record Transaction Reference Number; 2) Transaction Header Processor Control Number; 3) Insurance Group ID; 4) Workers Compensation Claim Reference ID; 5) Prior Authorization; 6) Alternate ID.

Action Item: Lori Petre
Email the health plans the options for the health plan claim number.

## 3. Business Continuity Plan

### Business Continuity Plan

This is follow-up to Business Continuity Plan which could also be known as Disaster Recovery. We talked about BPC two weeks ago; I do not have anything new to share with you as there has not been an AHCCCS agency meeting since we last met. It is scheduled for tomorrow. We left this as a topic of discussion on the agenda just in case you had any questions. We anticipate sharing more with you about AHCCCS' plan and how it can be communicated. One thing that I am concerned about is that the communications that go out to the health plans are joint business plans and IT plans. I do not want one going one way, and the other going the other way as that gets us all in trouble eventually. Those are things that I will be following up on from an IT perspective.

## 4. Follow-Up Items

### Co-Pays (Dan Lippert)

Last time we talked about co-pays, we mentioned that we were going to start doing them daily. The big issue was where the effective date for the co-pay was going to go. You have a memo in the handouts. We are going to use the Loop 2000 Member Level Date Segment for the "as of date" for the co-pays. When you have a Process Date or Qualifier 303, that is going to be the "as of date" when a co-pay is present. If you are more used to the proprietary format, that is the same as the "CP begin date". There is an example attached.

Q: What are the rules on your co-pay? Are you going to tell us the co-pay as of five days in advance or the day before two days after?
A: It is going to be the day it is effective.

Q: What are the plans for putting this in proprietary?
A: Lori Petre – At this time, there is not intention to put this in a proprietary format, and let me explain why. The only plans still receiving the proprietary format who would care about co-pays are operating under a contingency. We have been told to really push those plans to close out those contingencies. If you are one of those plans, you are going to be hearing from me tomorrow to talk to you about coming up with a final, real go-live date.

Q: When are you going to implement the co-pay effective date?
A: Dan Lippert – The first daily after the April month end cycle.

Lori Petre – As you can see, that is a pretty reasonable window. When I talked to Kari Price, she said to really push to close those contingencies and not invest a lot of work into changing something where it was not a necessity. If you are still operating under a contingency, you will be hearing from me tomorrow.

Q: What system or process is feeding in the co-pay information? We have a scenario where we get co-pay information, and they have a mandatory co-pay. Then a couple of days later the member tells us or sends us a letter that they have a mental health situation going, and there is no co-pay so we go in and change it in our system. Then we get another envelope from AHCCCS, and we set it right back to mandatory. Then the member is back on our case saying, no, this is still going on, and we are looking like idiots to certain members.
A: Nancy Mischung – That is why this is being implemented daily. Today you only get co-pay changes on your last daily of the month.

Dan Lippert – Those are the type of complaints that caused us to go down this path. Now our system is going to be updated, and we are going to send you something that says that things have changed. We are not going to wait up to that 20-day window to notify you of that.

Health Plan – Currently the upstream process has not conveyed the information to AHCCCS, and AHCCCS is flipping back our changes.

Dan Lippert – Probably the best thing to have you do is send me an example that I can take from start to finish. What I will do then is be able to respond to you. If we see it is an inherent problem, we will let everybody know. If it is a timing issue that will be addressed with this change, I will let you know.

Nancy Mischung – We will have 834 test files available March 31st.

Lori Petre – We will send out a confirmation of that.

Action Item – Lori Petre
Send out a confirmation email regarding availability of 834 test files.

**Data Certification (Eric Stott)**

We gave a presentation two weeks ago regarding data certification. Nothing has changed since that discussion. Just a few of the questions that were raised, I now have answers for.

The first question that was raised was in the EDI file, what segment in the encounter file were we going to pull the amount from? It is in the CLM02, the claim total charge amount.

The other question was when were we going to start testing this. Testing will begin on the 27th of February. That is when we are going to start the data certification testing.

Lori Petre – What that means, if you are submitting 837 tests for next week and the following week, we will take those without certifications. Starting the 27th, if you submit an 837 test, we are going to look for that certification.

**5. Other (Lori Petre)**

**Open Issues/Action Items**

Lori Petre – We were going to verify that reference issue; that the data that was comprised in the references files was matching up to the matrices. Brent, did you have a chance to verify this?
Brent Ratterree – One thing that I know was a concern was that not all of the new rates were posted to the reference files. I have confirmed that all those new rates were posted to the reference files. The next step is how that is coming across to you, and we need to verify that information. Everything is current in the system now. If you have a specific example, go ahead and email us with that so we can take a look at it. This information is current as of this month.

One of the things that Melonie does is from the meeting minutes, you will see that she notes a lot of action items in those minutes. She then sends us all a list of those things that we are supposed to respond to in this meeting.

One of the things that I said that I would share with everyone, which I do not have yet at this point, is our final dates associated with the 276/277 transaction. We should be able to provide that within the next week or so.

**Upcoming Meetings**

The next meeting is scheduled for 3/3/04; same time and same place. You will probably see some things emailed out to you prior to then related to NCPDP, anything with the 837 that is a question or issue.

**Project Schedule/Encounters (Lori Petre)**

On the project schedule, an important date coming up for you is on the 3rd page. Trading Partner testing for the 837 encounters starts Monday. We have been conducting internal tests now for 3 weeks. Those are going well. We have identified some issues, which is good. We are ready to take the transactions effective Monday. Currently what we have planned on doing, is that we will take transactions every day, we will process them through Mercator every day. We will run the encounter edits and audits process daily, but we will only run the adjudicated encounter 277U and appended on Tuesday's and Thursday's just to try and maximum those windows. We will monitor that, and if we find that it is not working, we will change that schedule. I will send you all an email confirming that.

Action Item: Lori Petre
Send email confirming the Trading Partners testing of 837 encounters.

We do have internal status meetings with Brent Ratterree and Lydia Ruiz on a weekly basis so their staff will also be pretty informed on what is going on with those transactions.

I will also be sending out an email to each health plan just trying to ascertain your readiness to begin testing on Monday so that we will get a feel for what is going to happen with that.

Action Item: Lori Petre
Send email to each health plan to ascertain readiness to begin testing Monday.

If you would like to shoot me an email when you send in your first test file, we will watch for it specifically. One of things that you will get in addition to the acknowledgements going out in your FTP directory is a daily status report, and Tom and Ted are going to start doing that tomorrow. This status report is emailed out to the submitter everyday. If you submitted yesterday, I will email to you today what happened with the disposition on those files. That way you will be getting the information from that direction as well as from your directory.

**6. Wrap-up**

I think that is all I have. I have not signed in on the Sign-In sheet, please do so. If you have anything else, let us know. Meeting adjourned.